Provincial Court of Newfoundland and Labrador

Happy Valley Goose Bay

In the matter of a
Judicial Inquiry
into the circumstances
of the death of
August Zarpa,
who died at the Labrador
Correctional Center on
June 13, 2003

Introduction

August Zarpa took his own life by hanging while incarcerated at the Labrador Correctional Center on June 13, 2003. On June 10, 2004, the Director of Public Prosecutions sent a copy of the investigative file to the Chief Judge, who then asked the undersigned to conduct an inquiry into the causes respecting and the circumstances surrounding that death. This report summarizes the evidence heard during the inquiry, recognizes the recommendations made following an internal investigation into the death, sets out the cause and manner of death, and concludes that any recommendations which might otherwise have been appropriate to avoid a

similar death in the future have already been instituted by the correctional authorities.

Evidence

We heard from a number of witnesses, which testimony I will summarize in the order heard.

Constable Devereaux related to the inquiry the results of an investigation conducted by the RCM Police, and tendered the report compiled by Corporal Burnett as exhibit LD 1. She also tendered into evidence the sneaker laces used, the suicide notes, the scene photographs, and other papers found in the cell.

The second witness was Mark Mahoney, a corrections officer for less than two years. On June 13, 2003, Mahoney went to work at 8:00 a.m., working a twelve hour shift. He said that Zarpa had been confined to his cell, having been charged with an institutional offence, and so had taken his meals that day in his cell. Mahoney remembered serving Zarpa his supper, and that Zarpa had smiled at him, and seemed to be in a normal state of mind.

However, at approximately 7:15 p.m., while Mahoney was conducting another body count, he looked in Zarpa's cell, and could not see the inmate. He

kicked the door, but got no response. On opening the cell door, he saw Zarpa hanging by his sneaker laces from the air vent located over the toilet.

Mahoney checked Zarpa, but found no pulse. He secured the cell, and immediately reported his having found Zarpa to Acting Lieutenant Flanigan, the officer in charge of the institution that evening.

A/Lt. Flanigan, and corrections officers Budgell, Best and Mahoney went to the cell. Best locked down the other prisoners, while Flanigan and Mahoney cut Zarpa down, following which CPR was attempted by Mahoney and Budgell. CO Hickman was asked to call an ambulance, and did so from the control room.

The ambulance arrived within approximately five minutes: however, since no pulse had been detected from the time Zarpa had been found hanging in his cell, it is not surprising that the CPR attempted by the correctional officers, and repeated by the emergency responders, was unsuccessful.

A/Lt. Flanigan testified, and explained that he had been the officer in charge in the institution on June 13, 2003, and that, around 7:00 p.m., he had asked the corrections officers to conduct a formal count of the inmate population prior to the shift change at 8:00 p.m. It was during that process that CO

Mahoney had reported to him that he had found Zarpa hanging in his cell.

A/Lt. Flanigan also remarked that he had seen Zarpa earlier in the day, and that, other than wanting cigarettes, the inmate had seemed fine to him. By his watch, Flanigan had noted the call for the ambulance to have been made at 19:18, with the ambulance arriving only five minutes later, at 19:23.

The practice of the institution had been to confine prisoners to their cells pending resolution of disciplinary matters, with a written Notice of Allegation being given to the inmate on being so confined to his cell. Co-incidentally, when the cell was searched post mortem, a copy of an earlier such Notice, relating to Zarpa having breached the institutional rules on April 28, 2003, allegedly by having been in another inmate's cell, was found, and was tendered during the inquiry as exhibit LD 8.

While it is noted that, having been confined to his cell from June 9, to June 13, 2003, might have contributed to his despondency, having been through the process in April, Zarpa would have known that his confinement would be until the disciplinary process had concluded. That practice has since changed, so that a disciplinary hearing is either held within 24 hours of the prisoner being

locked down, or else, the prisoner is released from his cell after 24 hours, whether the disciplinary process has been completed or not. Here it must also be noted that the confinement to cell was not unique to Zarpa: he and another inmate had allegedly been fighting, and so both of them were confined to their respective cells.

The next witness was Arch Pardy, a correctional officer who arrived at the Labrador Correctional Center around 19:15, ready to work the night shift from 8:00 p.m. to 8:00 a.m. The ambulance had arrived there before him, and the corrections officers and emergency response team were working on Zarpa in an attempt to resuscitate him. Pardy secured the cell by locking it and taping over the lock pending an investigation.

The next witness was Maurice Best, a corrections officer with the LCC since 1984. Having completed his count on units 1 and 2, Best was going to the control room to report his count when he saw Mahoney come out of the unit where Zarpa was kept. While Flanigan and Budgell and Mahoney were taking Zarpa down, Best locked down the other inmates. When Best returned to Zarpa's cell, Budgell was performing chest compressions, while Mahoney was attempting to revive Zarpa by giving him mouth to mouth. These efforts were

unsuccessful, but continued right up to the arrival of the emergency medical technicians with the ambulance.

The next witness was corrections officer James Hickman. On June 13, 2003, he performed general duties until 17:00 hours, when he went to relieve the person on duty in the control room. At Flanigan's request, Hickman telephoned for the ambulance at 19:15 hours, and he confirmed that the ambulance arrived five minutes later. They were escorted to Zarpa's cell, and took the deceased to the hospital, where he was pronounced dead a short time later.

The seventh witness was A/Supt. Roy Holloway, who has been the administrator of the Labrador Correctional Center since 2000. Since June 13, 2003 was a Saturday, he was not in the institution when Zarpa hung himself. However, he was called at his residence around 8:00 p.m., and went to the facility to ensure that the operational policies relevant to an inmate death were being followed, and also to ensure that the staff were okay.

Holloway confirmed that Supt. Scoville arranged for A/Supt. George Head, who is stationed at the Bishop's Falls Correctional Center, to carry out an internal investigation, and to make recommendations to avoid a similar episode

in the future. Those recommendations included a reduction to twenty-four hours as the amount of time that an inmate would be confined to his cell before either being tried for the alleged disciplinary offence or being released, as well as regular visits to the institution by a psychiatrist.

On admission to the institution, said Holloway, inmates are screened for assessment as to suicidal ideation. That process incorporates evidence from the inmate personally, but may also include information relevant to the risk of suicide from police , probation, or other sources, such as expressions of concern raised by family members.

If there is some concern raised by the suicide assessment, then inmates may be classed as yellow [moderate] or red [elevated] alerts. An inmate on yellow alert is subject to periodic surveillance, and is checked every thirty minutes. An inmate on red alert is confined to his cell, and subjected to video surveillance constantly. Inmates exhibiting suicidal ideation are referred up a "chain of command", first to the nurse, then to the local physician, and, if necessary, to a psychiatrist.

Holloway also confirmed that inmates who mention suicide are not

routinely escorted to the local hospital as potential patients under the Mental Health Act. At the risk of appearing cynical, if such a policy were adopted, predictably it might encourage an increase in the number of false complaints of suicidal ideation, if only for an unscheduled sojourn away from the institution.

The next witness was Lt. Linda McBay, who has been with the Labrador Correctional center since 1985. She confirmed that inmates are assessed for suicidal ideation on their admission to the institution, and that a form is completed which questions the inmates about their thoughts on suicide. That form is then filed with the other paper work about the inmate, and is available to be seen by the nurse and the physician. Lt. McBay tendered in evidence a form from Zarpa's admission to the institution in 2001, when he admitted to once having taken an overdose of Ritalin and Atasol: that became exhibit LM1. However, said Lt. McBay, she did not recall anything unusual about Zarpa during his admission to the facility in 2003.

The next witness was Correctional Officer Budgell, who, in anticipation of relieving CO Mahoney at the shift change due for 8:00 p.m., arrived at the institution at 7:15 p.m., coincidental to the discovery by CO Mahoney of Zarpa's body in his cell. Budgell assisted with CPR from the cell to the ambulance, and

traveled in the ambulance to the local hospital, where Zarpa arrived at 7:33 p.m., and was pronounced dead at 7:41 p.m.

Budgell advised that his CPR was current, having completed the course in 2001, and that he never detected any pulse in Zarpa during any part of his dealings with Zarpa that evening.

Budgell also advised that he was familiar with Zarpa from having previous dealings with him, and that Zarpa had never expressed any suicidal ideas to him: as he said, "he [Zarpa] seemed normal to me".

The next witness was Tobias Bauld, who has twenty-two years with the corrections system in this Province, including three years in the rank of Lieutenant.

Lt. Bauld confirmed the practice of having a commissioned officer meet all new inmates admitted to the Labrador Correctional Center, where and when a suicide risk assessment is carried out before the inmate is turned over to the correctional officers for search, shower, and further processing.

Most of the information used to assess an inmate's suicide risk comes from the inmate himself, but Lt. Bauld confirmed that other sources of

information, including the RCM Police, sometimes help identify a risk of suicide. Once identified, either as a yellow [moderate caution] or a red [elevated risk] code, the inmate will be either closely or constantly under surveillance, respectively.

In relation to Zarpa personally, when exhibit TB 1, a suicide risk assessment form was completed on March 19, 2003, after Zarpa had been sentenced, Lt. Bauld asked Zarpa about his disclosure of a suicide attempt in 1998, four years earlier. Lt. Bault remembered, and recorded on the form, that Zarpa had made a remark that his ideas of suicide were "all in the past".

Lt. Bauld concluded his evidence by advising that he was very surprised when he learned of Zarpa's suicide, because there had been no indication in Zarpa's words or actions to suggest that he was even considering making away with himself.

The eleventh witness was Assistant Superintendent George Head, who was tasked with conducting an internal investigation following the events of June 13, 2003, and was immediately dispatched from Bishops' Falls to Happy Valley- Goose Bay for those purposes.

A/Supt. Head reviewed the events, analyzed these in terms of compliance with the operational policy and procedure then in place, and made a report to Superintendent Scoville, setting out his findings, and making certain recommendations. I will briefly review these.

Findings made by A/Supt. Head were that the staff had fully complied with all policy and procedures then in place. Specifically, he said that the two-man "cut-down" procedure for a hanging victim was correctly followed, as was the means used by A/Lt. Flanigan in cutting the ligature by avoiding cutting the knot used to join the sneaker laces. Similarly, the correctional officers had immediately and correctly attempted "two-man" CPR, the RCMP and senior authorities had been correctly and promptly notified, the scene had been secured, and all incident reports had been compiled and filed by staff members in a timely manner, and without any collaboration. Staff members had been debriefed within 48 hours, and Assistant Superintendent Head concluded that all staff had acted within the best traditions of the service. Here I note that I agree with Assistant Superintendent Head in these conclusions.

The investigation completed by A/Supt. Head was comprehensive, and revealed that no suicidal indicators on Zarpa's part had been noted by the staff,

or reported by any other source, including other inmates. Typically, suicide risk may present by unusual changes in appetite, or sleeping patterns, or an inmate might be noted to be crying, depressed, or expressing feelings of hopelessness. None of these had been observed by the staff, including the nurse, and even two inmates, who subsequently admitted to having smuggled two cigarettes to Zarpa during his confinement to his cell[1] denied any knowledge that Zarpa had been considering taking his own life.

In terms of other findings, A/Supt. Head considered that towel bars and ventilation vents then present in the facility might present as potential suicide aids, concluded that pre-hearing confinement might have contributed to Zarpa's mental state, and recognized that mental health issues seemed to be common among the inmates in the facility. These findings led him to make recommendations to remove the towel bars, replace the ventilation grills, change the pre-hearing confinement process in disciplinary matters, and increase the availability of psychiatric services to inmates of the Labrador Correctional Center.

---

[1]Tobacco was, at the time, still available to inmates in the Labrador Correctional Center.

All of Assistant Superintendent Head's recommendations were implemented. In fact, the pre-hearing confinement period pending disciplinary tribunal hearing was reduced on a Province-wide basis.

The twelfth and final witness heard during the inquiry was Superintendent of Prisons John Scoville. His evidence included his involvement after being notified of Zarpa's death shortly after the incident, dispatching A/Supt. Head to conduct an investigation, and then ensuring that all of the recommendations made following the investigation were put into place.

Just as he was arriving in Grand Falls on the evening of June 13, 2003, Superintendent Scoville received a cell phone call, alerting him to Zarpa's sudden death. He remained in contact with the LCC during the evening, and also reported the initial information to Assistant Deputy Minister Alcock and to the Director of Adult Corrections, Marvin McNutt.

The following day, he asked A/Supt. Head to undertake the investigation, and the day after that Head was en route to Happy Valley Goose Bay. Superintendent Scoville tasked Assistant Superintendent Head to conduct the investigation because the latter has a lot of experience within the corrections

system, and has the skill and personality to conduct an effective and thorough investigation. In this regard, I agree with Scoville's choice of A/Supt. Head as the investigator.

I have already mentioned that Scoville has acted upon all of the recommendations made by Head following his investigation. Let me now review these in turn.

In the LCC, the cell ventilation grates have been replaced with a secure, screened version, which is designed so that a person contemplating suicide cannot put any kind of ligature through the grill work. There is some debate about the efficacy of this in terms of preventing suicide, because a determined person may be remarkably creative in trying to kill himself. However, it is now much more difficult, if not impossible, for a suicidal person to take his life using the ventilation grills in the cells in the Labrador Correctional Center.

Another, perhaps more effective, means of reducing suicide risk has been the adoption of the "Living Works" program, an internationally recognized training program used to identify and assess suicide risk factors, and thereby identify those persons who may be contemplating suicide.

All staff have now been trained using this course. It incorporates information received from the inmate, as well as other sources, such as the police, Corrections Canada, and Pre-sentence reports prepared by Adult Probation services, and, as noted above, all inmates are screened immediately upon admission to the institution.

As to changes made in the internal disciplinary processes, Superintendent Scoville said that, on A/Supt. Head's recommendation, he directed a review be done of the process, which was carried out by commissioned officers from Her Majesty's Penitentiary and the Clarenville facility.

That review in turn recommended significant changes to the "due process" safeguards in the internal disciplinary procedures, which had last been revised in 1986. These changes have now been made, so that, in the vast majority of disciplinary cases, an inmate will rarely be confined to his cell for more than 24 hours prior to being tried for the alleged institutional offence, and will not be confined to his cell pre-trial for a minor offence. In cases of alleged serious offences, such as assault of another inmate, then pre-trial confinement to cell cannot exceed 72 hours without prior approval by a senior commissioned officer, and then can only extended for 24 hours unless there are exigent

circumstances.

As Superintendent Scoville explained, because of concerns for operational safety, in the event of a "lock down" of an entire building, then some matters might have to extend past these time frames, but that, generally, these safeguards will serve to limit pre-trial cell confinement to less than 24 hours. It is to be noted that, having been ordered confined to his cell for an alleged incident of fighting with another inmate, Zarpa might still have been in his cell four days pre-trial, even under the revised procedure. However, safety concerns must override due process when one is faced with potential violence among prisoners.

One of the deficits noted by Assistant Superintendent Head was what he perceived to be a requirement for more regular provision of psychiatric services for the inmates of the Labrador Correctional Center. Accordingly, he recommended that more resources be committed to achieve that end.

Superintendent Scoville has acted on that recommendation, and has changed the schedule so that the psychiatrist now visits the LCC on a monthly basis.

In terms of the yellow and red coding for suicide risks, yellow risk inmates

are so classified when there are concerns raised, but where the risk of suicide is not considered to be so severe as to warrant constant surveillance, which is used with red-coded suicide risk inmates. Given that suicidal ideation may present when an inmate is despondent over loss of control over his life, taking away things and prematurely confining an inmate under close surveillance could exacerbate matters, and actually drive such an inmate deeper in despair.

Historically, this Province has had a relatively low inmate suicide rate, compared nationally. However, the number of suicide attempts among the inmate population is comparable to the national average. The fact that suicide attempts are unsuccessful is due in large part to vigilance by correctional staff, who do a very good job of identifying suicide risks among the inmates.

However, there were no indications reported about, or observed of, August Zarpa in the year 2003 which might have raised any concern about his becoming a suicide risk. While he had disclosed a suicide attempt in 1999, this was four years earlier, and, on his admission to the LCC, he told the authorities that that was all in the past.

Regrettably, it appears that Zarpa's suicide was an impulsive decision,

made without any prior indication to his family, his fellow inmates, or the corrections staff that he was considering taking his own life.

Cause of death

There is no doubt that August Zarpa killed himself: he was seen hanging from a roof vent by sneaker laces around his neck, and, because he had been confined to his cell four days earlier, no other inmate could have participated in hanging him. Dr. Hutton's autopsy report, as well as the suicide notes found in the cell post mortem, confirm that Zarpa had resolved to take his own life.

Circumstances of death

The suicide notes clearly show that Zarpa was despondent for several reasons, including the fact that he missed his family, the fact that he had been confined to his cell, and the fact that he was serving the longest sentence ever imposed on him. He had been sentenced to a total sentence of ten months in jail on March 18, 2003, for a number of offences, including breaking and entering and breach of probation. However, there was no indication from Zarpa to the prison personnel that Zarpa was contemplating suicide. On the contrary, CO Mahoney described Zarpa as having smiled at him only a short time before he

hung himself. And, of course, it can not be overlooked that he had earlier survived a term served in the institution despite having been assessed as potentially suicidal.

Section 49 of the Provincial Offences Act, SNL 1995 c. P-31, provides as follows:

49. (1) At the conclusion of the inquiry the presiding judge shall make a written report to the Attorney General which shall contain findings as to the following:

1. (a) the identity of the deceased;

(b) the date, time and place of death or the fire;

(c) the circumstances under which the death or fire occurred;

(d) the cause of death or the fire; and

(e) the manner of death.

(2) A report under subsection (1) may contain recommendations as to the prevention of similar deaths or fires.

(3) The findings of the judge shall not contain findings of legal responsibility or a conclusion of law.

(4) The report of the presiding judge shall be made not later than 6 months from the date of the beginning of the inquiry unless an extension of the time is granted by the Chief Provincial Court judge.

(5) Notwithstanding an order under subsection 27(2), the Attorney General may make available to a person, on payment of the prescribed fee, a copy of the report or a part of it.

Accordingly, it is my duty to report that August Zarpa, an Inuk male originally from Nain, Labrador, died at approximately 7:15 p.m. on June 13, 2003 in cell 35, Unit 4 of the Labrador Correctional Center. The cause of death was asphyxia by hanging, and the manner of death was suicide.

While there is no evidence that the confinement to cell for four days accelerated any plan by the deceased to kill himself, the internal investigation already conducted by A/Supt. George Head has led to a change in the policy that means that prisoners are now not confined to their cells pending disciplinary action for any more than 24 hours. Accordingly, there is no need to make any recommendation about changing the policy.

Similarly, there is now a regular [monthly] visit to the institution by a psychiatrist, again, due to the recommendations made following A/Supt. Head's investigation.

At the risk of sounding trite, it is practically impossible to make any place "suicide-proof". While it might be tempting to suggest that shoe laces not be afforded prisoners, it must be remembered that prison conditions are not meant to be cruel, unusual, or demeaning places: the inmates are sent there for rehabilitation and other goals of sentencing. Regrettably, there are

no universally recognized symptoms of suicidal ideation, and there was no outward manifestation in this case that Zarpa was seriously contemplating suicide.

While peer group counseling of potentially suicidal inmates might, in some cases, appear attractive, this is unworkable when the inmate has had to be confined to his cell for allegedly fighting with another inmate. Without disclosure, whether to the correctional officers, or to his peers, an inmate's suicidal ideation will not be discovered in time for appropriate intervention.

Given the rarity of inmate suicides in this Province, it would appear that the authorities have already addressed the concerns evident during the internal review.

Finally, my thanks are expressed for the able assistance in this inquiry of Mr. Strickland.

All of which is respectfully submitted, at Happy Valley Goose Bay, this 13th day of April, 2005.

Porter, PCJ

Inquiry Counsel Lloyd Strickland